

State Employee Health Plan

Medicare Options For Retiree/Direct Bill Members

Comparison Chart 2

Monthly Premiums (Medicare Plans with or without Part D, Superior Vision Services and Delta Dental): Member Only

Medical Plan (with or without Part D)	Monthly Premium for Medical Plan (with or without Part D)	Superior Vision Services: Basic Plan	Superior Vision Services: Enhanced Plan	Delta Dental
Coventry Advantra Freedom PPO with Coventry Part D	\$180.00	\$6.54	\$13.08	\$28.97
Coventry Advantra Freedom PPO with First Health Part D	\$251.00	\$6.54	\$13.08	\$28.97
Kansas Senior Plan C with First Health Part D	\$363.41	\$6.54	\$13.08	\$28.97
Kansas Senior Plan C without First Health Part D	\$195.41	\$6.54	\$13.08	\$28.97

IMPORTANT REMINDERS:

The premiums provided for vision and dental coverage above are separate from the premiums provided for the medical plans. Therefore, when calculating your total monthly premium, please be sure to add all three premium amounts, as applicable.

Kansas Senior Plan C - Medicare Payment Information

Medicare A – Hospitalization	Medicare B – Medical	Kansas Senior Plan C Supplement
<p>Inpatient hospital</p> <ul style="list-style-type: none"> First 60 Days: \$1,184.00 deductible* Days 61 through 90: \$296 per day Coinsurance* Lifetime reserve: \$592 per day Coinsurance* <p>Skilled Nursing Facility</p> <ul style="list-style-type: none"> First 20 days: 100% payment—no co-pay Days 21-100: \$148.00 per day Coinsurance* <p>Services Paid at 100%</p> <ul style="list-style-type: none"> Home health Hospice Benefit period ends when the patient is out of the hospital or skilled nursing facility for 60 consecutive days <p>There is usually no premium associated with Medicare Part A</p> <p>Coverage shown is per benefit period. A benefit period ends when the patient is out of the hospital or skilled nursing facility for 60 consecutive days</p>	<p>Annual Deductible \$147 deductible per calendar year* (January 1 through December 31)</p> <p>Medicare Coverage for Physician's Charges Medicare pays 80% of allowed charge; Beneficiary pays 20% Coinsurance* (in- or out-of-hospital)</p> <p>Durable Medical Expenses and Supplies</p> <ul style="list-style-type: none"> Ambulance Outpatient hospital charges Blood (first 3 pints) Lab services <p>Preventive Services</p> <ul style="list-style-type: none"> Bone mass measurement Cardiovascular screenings Colorectal screenings Diabetes screenings Flu shots Glaucoma tests Hepatitis B shots Pap tests 	<p>Kansas Senior Plan C pays for all costs shown in green to the left under Medicare Part A and Part B. In addition, Kansas Senior Plan C pays the following:</p> <ul style="list-style-type: none"> An additional 365 hospital days per lifetime Foreign emergency travel medical services: \$250 deductible, then the plan pays 80% to a maximum of \$50,000 lifetime If Medicare A and B do not cover the service, there is no benefit under the medical portion of Kansas Senior Plan C

- Pneumococcal shot
- Prostate cancer screening
- Screening mammograms
- Well Woman Exam
- Well Man Exam

Beneficiary must pay a monthly Medicare Part B Premium

* The deductible and coinsurance amounts listed on this chart reflect **2013** rates. Be sure to review your *Medicare and You* handbook for the new 2014 amounts.

Health Plan Comparison Chart

	Coventry Advantra Freedom	
	Preferred Provider Organization (PPO) - with Coventry Part D or First Health Part D prescription drug	
	Network Providers	Non Network Providers
Basic Provisions		
Provider Choice	Freedom to use provider of choice, benefits based on plan description: coverage level based on provider network status	
Coinsurance (for all eligible expenses, unless otherwise noted)	\$0	20% Coinsurance
Deductible	\$0	\$0
Annual Out-of-Pocket Maximum	\$1,000	20% with no max
Lifetime Benefit Maximum	No limit	No limit
Amounts Above Plan Allowance	Provider to write off	Balance billed to member
Preventive Care		
Preventive Care Services	\$0	20%
Age Appropriate Routine Physical Exam	\$0	20%
Well-Woman Care: office visit, PAP smear test & STD testing - CMS will cover one pap and pelvic exam every two years	\$0	20%
Well-Man Care: office visit & PSA blood test	\$0	20%

Mammogram	\$0	20%
Licensed Dietitian Consultation: <i>for medical management of a documented disease</i>	\$0	20%
Age Appropriate Bone Density Screening	Covered in full	20%
Routine Age Appropriate Colonoscopy	Covered in full	20%
Covered Services		
Routine Hearing Exam	\$0 Copay for each routine hearing test up to 1 per year, \$500 every 3 years for hearing aids	20%
Routine Vision Exam: <i>refraction exam for glasses; lenses & frames not covered</i>	\$0 Copay for PCP; \$0 Copay for specialist (limited to 1 routine visit per year)	20%
Inpatient Services	\$150 Copay per day up to 5 days	20%
Physician Hospital Visits	Included in the inpatient services Copay	Included in the inpatient services Copay
Physician Office Visits		
Primary Care Provider	\$10	20%
Specialist	\$25	20%
Urgent care center	\$30 Copay, worldwide coverage	\$30 Copay, worldwide coverage
Outpatient Surgery	\$150 Copay	20%
Emergency Room Visits	\$50 Copay (waived if admitted)	\$50 Copay (waived if admitted)
Ambulance Services	\$100 per one-way trip	\$100 per one-way trip
Major Diagnostic Tests*	\$75 Copay	20%
Home Health Care <i>services must be pre-approved by health plan</i>	Services must be pre-approved by health plan	Services must be pre-approved by health plan
Hospice <i>services must be pre-approved by health plan; limited to six months</i>	Services must be pre-approved by health plan	Services must be pre-approved by health plan

X-Ray and Laboratory Services	\$0 Copay for clinical/diagnostic lab service	20%
Physical Rehabilitation Services: <i>(services limited to those medically necessary and appropriate: medical records must show continued improvement)</i>	\$0 Copay per visit	20%
Inpatient facility	\$150 Copay per day up to 5 days	20%
Outpatient facility	\$0 Copay for PCP; \$0 Copay for specialist	20%
Office based	\$10 Copay for PCP; \$25 Copay for specialist	20%
Chiropractic	\$20 copay	20%
Durable Medical Equipment	20% Coinsurance	20% Coinsurance
Allergy Testing	\$10 Copay for PCP; \$25 Copay for specialist	20%
Antigen Administration: <i>desensitization/treatment; allergy shots</i>	\$10 Copay for PCP; \$25 Copay for specialist	20%
Covered Immunizations	Covered in full	20%
Prescription Drugs		
Prescription Drug Services	Prescription Drug Plan Details	
	Preferred Generic drug	\$5 Copay
	Preferred brand name drug	\$30 Copay
	Non-preferred Generic and Brand name drug	\$60 Copay
	Injectables	33% Coinsurance for speciality drugs
	Limit	The initial coverage limit is \$2,850 and is based on the applicable Copay plus the plan cost. After this amount is reached, there is generic-only coverage until your out-of-pocket costs reach \$4,550.
	Catastrophic coverage	\$2.55 Copay for generic or preferred brand name drugs and \$6.35 Copay or 5% Coinsurance, whichever is highest, for all other drugs. Catastrophic coverage becomes effective when your out-of-pocket costs reach \$4,550.

Mental Health

Mental Illness and Drug or Alcohol Treatment

Same coverage as medical

* **Major Diagnostic Tests:** includes but not limited to; PET scans, CT scans, nuclear cardiology studies, magnetic resonance angiography and computerized topography angiography. Most major diagnostic tests require pre-approval by the Health Plan.

The comparison chart is NOT the governing document. Members need to refer to each Provider's Benefit Description posted on www.kdheks.gov/hcf/sehp/BenefitDescriptions.htm under the Health Plan Carriers (Providers) button.

First Health Part D Plan Benefits			
Prescription	Network Retail / Mail Order 30 Day Supply	Network Retail / Mail Order 60 Day Supply	Network Retail / Mail Order 90 Day Supply
Tier 1 - Generic drugs	25% Coinsurance up to a \$30 maximum	25% Coinsurance up to a \$30 maximum	25% Coinsurance up to a \$45 maximum
Tier 2 - Preferred Generic drugs	25% Coinsurance up to a \$30 maximum	25% Coinsurance up to a \$30 maximum	25% Coinsurance up to a \$45 maximum
Tier 3 - Preferred Brand Name drugs	25% Coinsurance up to a \$100 maximum	25% Coinsurance up to a \$100 maximum	25% Coinsurance up to a \$150 maximum
Tier 4 - Non-Preferred Brand Name drugs	50% Coinsurance up to a \$150 maximum	50% Coinsurance up to a \$150 maximum	50% Coinsurance up to a \$225 maximum
Tier 5 - Speciality Only available in 30 day supply	33% Coinsurance up to a \$100 maximum	N/A	N/A
If out-of-pocket expenses exceed \$4,550	Generics: the greater of 5% Coinsurance or \$2.55 Brands: the greater of 5% Coinsurance or \$6.35	Generics: the greater of 5% Coinsurance or \$2.55 Brands: the greater of 5% Coinsurance or \$6.35	Generics: the greater of 5% Coinsurance or \$2.55 Brands: the greater of 5% Coinsurance or \$6.35

Delta Dental Benefits			
	Delta Dental PPO Network Provider	Delta Dental Premier Network Provider	Non Network* Provider
Annual Benefit Maximum	\$1,700 per member		
Lifetime Orthodontic Benefit	50% Coinsurance to a maximum of \$1,000 per member		
Implant Coverage (Benefit subject to Annual Benefit Maximum above)	50% Coinsurance		
DEDUCTIBLE			
Diagnostic and Preventive Services	No Deductible		
Basic Restorative Services	\$50 per person per Plan year Not to exceed an annual family deductible of \$150		
Major Restorative Services			
COINSURANCE			
BASIC BENEFIT			
Applies when you have <u>NOT</u> had at least one routine prophylaxis (cleaning) and/or preventive oral exam in prior 12 months			
Diagnostic and Preventive Services	Allowed Amount covered in full by the Plan*		
Basic Restorative Services	50%	50%	50%
Major Restorative Services	50%	50%	50%
ENHANCED BENEFIT			
Applies when you have had at least one routine prophylaxis (cleaning) and/or preventive oral exam in prior 12 months			
Diagnostic and Preventive Services	Allowed Amount covered in full by the Plan*		
Basic Restorative Services	20%	40%	40%
Major Restorative Services	50%	50%	50%

*Services by Non Network providers are subject to the Allowed Amount including the Maximum Plan Allowance for Non Network Providers. Any amounts in excess of the Allowed Amount will be the member's responsibility.

Your coinsurance will increase for Basic Restorative Services when you have not had a routine prophylaxis (cleaning) and/or preventive oral exam in the preceding twelve (12) month period. Ninety (90) days following receipt of a qualifying prophylaxis (cleaning) or preventive oral exam, you will qualify for the Enhanced Benefit Level. The Plan reserves the right to determine what services will qualify as meeting the definition of a routine prophylaxis (cleaning) and preventive oral exam. Routine prophylaxis (cleanings) and preventive exams shall not include any services provided on an emergency basis or for treatment of an injury to the teeth.

Superior Vision Benefits			
Service or Item	Basic Plan: Network	Enhanced Plan: Network	Both Plans: Non Network
Eye Exams: Subject to \$50 Copayment			
• Eye exam, M.D.	Covered in full after Copayment	Covered in full after Copayment	Up to \$38
• Eye exam, O.D.	Covered in full after Copayment	Covered in full after Copayment	Up to \$38
Eyeglasses: Subject to \$25 materials Copayment			
• Frame	Up to \$100 retail*	Up to \$150 retail*	Basic Up to \$45 Enhanced Up to \$78
• Single vision lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to \$31
• Bifocal lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to \$51
• Trifocal lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to \$64
• Lenticular lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to \$80
• Progressive lenses, pair	Not covered	Covered up to \$165*	Not covered
• High index lenses, pair**	Not covered	Covered up to \$116*	Not covered
• Polycarbonate lenses, pair**	Not covered	Covered up to \$116*	Not covered
• Scratch coat	Not covered	Covered in full	Not covered
• UV coat	Not covered	Covered in full	Not covered
Contact Lenses: Not subject to materials Copayment			
• When medically necessary	Covered in full	Covered in full	Up to \$210 retail*
• Elective/cosmetic retail	Up to \$150 retail*	Up to \$150 retail*	Up to \$105 retail*
Contact Lens Exam (fitting fee) (\$35 Copayment)			
• Specialty contacts***	Up to \$50*	Up to \$50*	Not Covered
• Standard Contacts****	Not Covered	Covered in full	Not Covered

*You are responsible for any charges above the allowance.

** You may only be covered for one pair of high index lenses or polycarbonate lenses under the Enhanced Plan (up to the allowance provided above).

*** Specialty contacts are for new contact lens wearers or patients who wear toric, gas permeable or multi-focal lenses; includes two follow-up visits within three months of initial fitting.

**** Standard contacts are for existing contact lens wearers of disposable, daily wear or extended lenses; includes two follow-up visits within three months of initial fitting.

Notes:

- Members can use either the contact lens benefit or the eyeglass benefit, but not both in the same plan year.
- For non network claims, copayment amounts are deducted from the benefit allowance at the time of reimbursement.
- Covered lenses are standard glass or plastic (CR-39), clear.